Division of
Health Care
Finance & Administration

Health Care
Innovation Initiative

Health Link TAG Recommendations and Program Information

October 20, 2016

Health Link member identification criteria

	Identification criteria
Category 1: Diagnostic criteria only	**A new or existing diagnosis or code of:** • Attempted suicide or self-injury • Bipolar disorder • Homicidal ideation • Schizophrenia
or	
Category 2: Diagnostic and utilization criteria	**One or more behavioral health-related (a) inpatient admissions or (b) crisis stabilization unit admissions (18 or over), ED admissions (under 18), or residential treatment facility admissions; WITH a diagnosis of:** • Abuse and psychological trauma • Adjustment reaction • Anxiety • Conduct disorder • Emotional disturbance of childhood and adolescence • Major depression • Other depression • Other mood disorders • Personality disorders • Psychosis • Psychosomatic disorders • PTSD • Somatoform disorders • Substance use • Other / unspecified
or	
Category 3: Functional need	**Up to 12/1/16: Receipt of 2 or more Level 2 Case Management (L2CM) services** **After 12/1/16: Provider documentation of functional need, to be attested to by the provider.[1]**

[1]Note: Functional need is defined as aligning with what the State of Tennessee has set out as the new Level 2 Case Management medical necessity criteria, effective March 1, 2016 for adults and April 1, 2016 for children. The look-back period for Category 1 and Category 3 identification criteria is April 1, 2016. The look-back period for Category 2 identification criteria is July 1, 2016.

Quality measures for Health Link providers

	Core measures used	Measures for reporting only (phase-in)
TAG-recommended Behavioral health quality measures	• 7-day and 30-day Psychiatric Hospital / RTF Readmission rate • Follow-up after hospitalization for mental illness within 7 days or within 30 days • Initiation/engagement of alcohol and drug dependence treatment • Antidepressant Medication Management[1] • Use of Multiple Concurrent Antipsychotics in Children and Adolescents[2]	• Prescription fill rate for BH related medications • Care transitions: Timely transmission of transition record (i.e., within 24 hours) • Appraisal for alcohol or chemical substance use[2] • Screening for Clinical Depression and Follow-up Plan • Care transitions: timely assessment and initiation of treatment by a mental health professional following discharge or referral (i.e. within 7 days) • Suicide Risk Assessment[1]
Physical health quality measures	• BMI and weight composite metric (composite)[3] • Comprehensive diabetes care (composite 1)[1, 4] • Comprehensive diabetes care (composite 2)[1, 5] • EPSDT: Well-child visits age 7-11[2] • EPSDT: Adolescent well-care visits age 12-21[2]	• Diabetes screening for people prescribed antipsychotic medications[1] • Cardiovascular health screening for people prescribed antipsychotic medications[1] • Annual monitoring of patients on persistent medications[1,6] • Infections disease (e.g., Hepatitis C, HIV, TB) screenings performed[1] • PQI 92: Chronic Condition Composite[1] • Controlling high blood pressure[1] • Statin therapy for patients with cardiovascular disease[6]

1 For adults only
2 For children/ adolescents only
3 Consists of two measures: adult BMI screening and weight assessment and nutritional counseling
4 Consists of three diabetes measures: eye exam, BP <140/90, and nephropathy
5 Consists of two diabetes measures: HbA1c poor control (>9%), HbA1c testing
6 Measure for reporting only

Core behavioral health quality metrics (1/2)

Recommended measure	Details	Source	Data collection methodology
7-Day and 30-Day Psychiatric Hospital / RTF Readmission[1]	• The number of members readmitted to a psychiatric inpatient or residential facility divided by the total number of members discharged from a psychiatric inpatient or residential facility during the respective time periods. The readmission is counted in the month that the readmission occurred (rather than the month of initial hospitalization or discharge.) Judicial and State-Only admissions should not be included in the calculation. – 30-day Readmission Rate - % readmitted within 30 days of discharge. – 7-day Readmission Rate - % readmitted within 7 days of discharge.	• TennCare	• Claims-based
Follow-up after hospitalization for mental illness within 7 or 30 days of discharge	• The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: – The percentage of discharges for which the member received follow-up within 30 days of discharge. – The percentage of discharges for which the member received follow-up within 7 days of discharge.	• HEDIS (FUH), CMS Health Home Core Set	• Claims-based

1 Currently in use by TennCare

Core behavioral health quality metrics (2/2)

Recommended measure	Details	Source	Data collection methodology
Initiation/ engagement of alcohol and drug dependence treatment	• The % of patients age 13+ with a new episode of alcohol or other drug (AOD) dependence who received the following: – Initiation of AOD Treatment (% who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis) – Engagement of AOD Treatment (% who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit)	• HEDIS (IET)	• Claims-based
Antidepressant Medication Management[1]	• % of 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant regime; report – Acute phase - % who remained on meds 84 days (12 weeks) – Continuation phase - % who remained on meds for 180 days (6 months)	• HEDIS (AMM)	• Claims-based (pharmacy claims)
Use of Multiple Concurrent Antipsychotics in Children and Adolescents[2]	• The % of children and adolescents 1-17 years of age who were on two or more concurrent antipsychotic medications: report by age 1-5, 6-11, 12-17, and total	• HEDIS (APC)	• Claims-based (pharmacy claims)

1 Adults only
2 Children/adolescents only

Core physical health quality metrics (1/2)

Recommended measure	Details	Source	Data collection methodology
Adult BMI screening[1]	• % of patients, ages 18-74 years, with an OP visit whose BMI was documented during the measurement year or the year prior	• HEDIS (ABA)	• Claims-based, claims-based with chart review
Weight assessment and nutritional counselling[2]	• Weight assessment and counseling for nutrition for children/adolescents ages 3-17 including BMI	• HEDIS (WCC)	• Claims-based
EPSDT Well-child visits age 7-11[2]	• % of members 7–11 years of age who had one or more well-child visits with a PCP during the measurement year	• TennCare	• Claims-based
EPSDT Adolescent well-care visits age 12-21[2]	• % of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	• HEDIS (AWC)	• Claims-based

1 Adults only
2 Children/adolescents only

Core physical health quality metrics (2/2)

Recommended measure	Details	Source	Data collection methodology
Diabetes: Retinal exam[1]	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes who had an eye exam (retinal) performed	• HEDIS (CDC)	• Claims-based, claims with chart review, or CPT II codes
Diabetes: BP < 140/90[1]	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes whose most recent blood pressure reading is less than 140/90 mm Hg (controlled)	• HEDIS (CDC)	• Claims-based, claims with chart review, or CPT II codes
Diabetes: Nephropathy[1]	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes who received medical attention for nephropathy	• HEDIS (CDC)	• Claims-based, claims with chart review, or CPT II codes
Diabetes: HbA1c poor control (>9%)[1]	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes whose most recent HbA1c level during the measurement year was greater than 9%	• HEDIS (CDC)	• Claims-based, claims with chart review, or CPT II codes
Diabetes: HbA1c testing[1]	• % of patients 18 to 75 years of age with type 1 or type 2 diabetes who had an HbA1c test performed in the measurement year	• HEDIS (CDC)	• Claims-based, claims with chart review, or CPT II codes

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1 Adults only

Health Link activity requirements (1/4)

	Activity requirements for Health Link providers
1 **Comprehensive care management**	**Initiate, complete, update, and monitor the progress of a comprehensive person-centered care plan (as needed)**, following a comprehensive assessment of the patient's behavioral and physical health needs within 30 days of patient enrollment. The plan should address the patient's behavioral health treatment and care coordination needs, including protocols for treatment adherence and crisis management, incorporating input from: • the patient • the patient's social support • the patient's primary and specialty care providers (within 90 days of enrollment with the Health Home)
2 **Care co-ordination**	**Participate in patient's physical health treatment plan** as developed by their primary care provider, as necessary
	Support scheduling and reduce barriers to adherence for medical and behavioral health appointments, including in-person accompaniment to some appointments
	Facilitate and participate in regular interdisciplinary care team meetings; include the PCMH / PCP when possible
	Follow up with PCP to understand significant changes in medical status, and translate into care plan
	Proactive outreach with PCP regarding specific gaps in care
	Follow up with other behavioral health providers or clinical staff as needed to understand additional behavioral health needs, and translate into care plan

Health Link activity requirements (2/4)

	Activity requirements for Health Link providers
3 **Referral to social supports**	**Identify and facilitate access to community supports** (food, shelter, clothing, employment, legal, entitlements, and all other resources that would reduce barriers to help individuals in achieving their highest level of function and independence), including by providing referrals, scheduling appointments, and following up with the patient, their relevant caregivers, and these community supports
	Communicate patient needs to community partners
	Provide information and assistance in accessing services such as: self-help services, peer support services; and respite services.
4 **Patient and family support**	**Provide high-touch in-person support** to ensure treatment and medication adherence (including medication reconciliation, medication management for specialty medications, medication drop-off, help arranging transportation to appointments)
	Provide caregiver counseling or training to include, skills to provide specific treatment regimens to help the individual improve function, obtain information about the individual's disability or conditions, and navigation of the service system.
	Identify resources to assist individuals and family supporters in acquiring, retaining, and improving self-help, socialization and adaptive skills.
	Check-ins with patient to support treatment adherence

Health Link activity requirements (3/4)

Activity requirements for Health Link providers

5 Transitional care

Provide additional high touch support in crisis situations when other resources are unavailable, or as an alternative to ED / crisis services

Participate in development of discharge plan for each hospitalization, beginning at admission to support patient's transition. This includes emergency rooms, inpatient residential, rehabilitative, and other treatment settings

Develop a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following:

- Receipt of a summary of care record from the discharging entity
- Medication reconciliation
- Reevaluation of the care plan to include and provide access to needed community support services
- A plan to ensure timely scheduled appointments

Establish relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, and long term services and supports providers to promote a smooth transition if the patient is moving between levels of care and back into the community

Communicate and provide education to the patient, the patient's supporters, and the providers that are located at the setting from which the person is transitioning, and at the setting to which the individual is transitioning

6 Health promotion

Educate the patient and his/her family on independent living skills with attainable and increasingly aspirational goals

Health Link activity requirements (4/4)

7

Population health manage-ment

Activity requirements for Health Link providers

Track and make improvements based on quality outcomes distributed in reports from MCOs

Identify highest risk patients on a continuous basis, supported by the Care Coordination Tool, and align with organization to focus resources and interventions

Meet CMS e-prescribing requirements[1]

Participate in practice transformation training and learning collaboratives at which best practice on a variety of topics, including health promotion, will be disseminated

Receive ADT notifications for the patient and continue ongoing use of the Care Coordination Tool

1 Activity requirement comes into effect in Year 2 of the program

Ongoing verification of Health Link eligibility requirements

	Requirements	Ongoing verification (if applicable)
Commitment	• **Stated commitment** to collaboration with primary care (i.e., documentation of agreement of collaboration with PCP)	• **Ongoing check in with primary care representative to verify continued collaboration**
Provider type	• **A Community Mental Health Center** • **Other qualified Health Link provider** (i.e., mental health clinic, FQHC, PCP, or BH specialty) with at least [250] assigned Health Link members across all MCOs[1]	

Tools	• **State care coordination tool:** Commitment to adoption of care coordination tool
	  ▫ Create unique ID and identify roles
	  ▫ Completion of training
	  ▫ Use of Tool for care transitions
	• **e-Prescribing:** Documented plan to progress toward CMS e-prescribing requirements by October 2017[2]	

Personnel	• **One individual designated as Health Link point of contact**
	• **Identification of a care team, including:**
	  ▫ Lead clinical care coordinator(s): A Registered Nurse, to coordinate with medical professionals
	  ▫ Case manager(s) to be primary point of contact for patient and family relationship
	• **Capability to provide behavioral health services** onsite (i.e., either on staff or through affiliation), with either:
	  ▫ A **psychiatrist**, or
	  ▫ A **licensed master-level mental health professional** and **a primary care physician**, or
	  ▫ A **psychologist** and **a primary care physician**
		• **Annual submission of personnel roster may be requested by the State**

1 Exceptions may be made for rural areas or counties in which there would not otherwise be a Health Link
2 CMS e-prescribing requirements include exchange of medication history, formulary and benefit information, and fill status notification, among others

Personnel qualification detail

	Definitions
Lead clinical care coordinator	• A Registered Nurse, licensed to practice in Tennessee
Clinical care coordinator	• Possessing, at minimum, a bachelor's degree, or an RN or LPN, licensed to practice in Tennessee
Case manager	• Possessing, at minimum, a bachelor's degree, or an RN, licensed to practice in Tennessee
Psychiatrist	• A psychiatrist with an active Tennessee license
Physician	• A primary care MD or DO licensed to practice in Tennessee
Psychologist	• A psychologist with an active Tennessee license with a health service provider designation
Licensed mental health professional	• A licensed mental health professional possessing a master's degree tied to mental health practice (or related subjects). The mental health professional may be: a psychological examiner or senior psychological examiner; licensed master's social worker with 2 years of mental health experience or licensed clinical social worker; marital and family therapist; nurse with a master's degree in nursing who functions as a psychiatric nurse; professional counselor; or if the person is providing service to service recipients who are children, any of the above educational credentials plus mental health experience with children. The appropriate license must be an active Tennessee license

Workforce: recommended staffing roles and ratios for Health Links

	Description	Example activities performed	Suggested staffing ratio[1]
Manager	• Possessing, at minimum, a bachelor's degree, or an RN or LPN	• Oversee all Health Link staff • Serve as a liaison between administrators and clinical staff	• 1:1000 manager to patient ratio
Lead Clinical care coordinator	• Registered Nurse	• Oversee a team of clinical care coordinators • Provide clinical direction to the appropriate care coordination staff	• 1:1000 lead care coordinator to patient ratio
Clinical care coordinator	• Possessing, at minimum, a bachelor's degree, or an RN or LPN	• Develop and update treatment plans • Referrals to and communication with providers • Using the Care Coordination Tool to prevent gaps in care	• 1:200 care coordinator to patient ratio • Implied ~40 minutes spent on care coordination activity for each member every month
Case manager	• Possessing, at minimum, a bachelor's degree, or an RN	• In-person check-ins with patient • Collateral contacts (e.g., family member education) • High-touch supports (e.g., transportation, medication drops)	• 1:45 case manager to patient ratio • Implied ~3 hours spent on each member every month
Other potential care team members	• Nutritionists, dieticians, health educators, pharmacist, peer supports, and others	• Roles may vary	• To vary based on population and provider needs

- Roles and ratios outlined here are recommendations, rather than program requirements

1 Staffing ratios to vary based on mix of select patient population, and is approximated for the current definition of identified population in Tennessee

Source: Interviews with clinicians

Sample stated commitment of collaboration between a Health Link and primary care

ILLUSTRATIVE EXAMPLE

I, [Name], on behalf of [Tennessee Primary Care Provider X] [date]

Agree over the next year, beginning from the stated date on this form, to collaborate with [X Site], which is part of [X Health Home], in the delivery of primary care services for our shared members of said Health Link.

This collaboration will involve:

- Accepting, and meeting the primary care needs of, patients referred by [X site] of [X Health Link], in a timely fashion
- Referring, where appropriate, members within my practice to [X site] of [X Health Link] for the delivery of behavioral health services

[Named Person] within my practice will act as primary point of contact for the Health Link over the course of this year. Their contact details are:
[email]
[phone]

The primary point of contact at [site x] of [Health Link provider x] for my practice is [Named Person]. Their contact details are:
[email]
[phone]

[Signature of PCP representative] [Signature of Health Link representative]

- A commitment to collaborate with a PCP is required **at launch for each Health Link provider organization**
- For integrated organizations or sites, the on-site PCP is eligible to complete the form
- **Within 6 months, each Health Link provider site must have a signed commitment to collaborate with a PCP**.
- Commitments with PCPs:
  - The PCP must be within 30 miles of the Health Link site (exceptions will be made for rural areas)
  - The PCP must be a TennCare provider.
- The signed and dated commitment must be submitted as an attachment to the **Health Link application. If your organization has multiple PCP commitments covering multiple sites, a cover letter can be written to attest to these commitments.**

Health Link sources of value

Cross cutting sources of value (behavioral and physical health)

- **Appropriateness of care setting and forms of delivery**
- **Increased access to care** (e.g., open office hours, open scheduling for walk-in appointments, and after-hours availability)
- **Improved treatment adherence** (e.g., adherence to mood stabilizer regiment, adherence to scheduled PCP visits)
- **Medication reconciliation**

Behavioral health sources of value

- **Referrals to high-value behavioral health providers**
- **Medication management** for specialty medications

Physical health sources of value[1]

- **Enhanced chronic condition management** (e.g., more frequent monitoring of A1c for diabetics)
- **Appropriateness of treatment for physical health conditions**
- **Reduced readmissions** through effective follow-up and transition management

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1 Health Link model would have ability to influence settings of care outside of physical health (e.g., inpatient hospital stays) through chronic behavioral health condition management

Curriculum of training and technical supports

Health Link leaders	• **Business support** (e.g., how to financially succeed as a Tennessee Health Link) • **Workflow management** (e.g., designing new clinical workflows to enable person-centered care) • **Patient access** (e.g., flexible scheduling, expanded hours) • **Workforce management** (e.g., recruiting clinical care coordinators, Health Link organization / reporting structure)
Clinical care coordinators	• **Management training** (e.g., how to engage Health Link staff) • **Clinical workflows** (e.g., detailed process for when a member is admitted into inpatient psychiatric treatment) • **Patient engagement** including individual and organization-level methods
Case managers	• **Patient education and support** (e.g., developing and communicating a plan for getting patients comfortable using TennCare transportation) • **Family and community engagement** (e.g., developing a plan for a family member to take patient to appointments, over time) • **Clinical workflows** (e.g., detailed process for when a member is admitted into inpatient psychiatric treatment
Direct clinical service providers	• **Clinical workflows** (e.g., knowing when and how to engage care coordinator) • **Patient engagement** (e.g., motivational interviewing)

Key practice transformation services to be provided

Pre-transformation assessment	• An initial, rapid, standardized assessment to develop a tailored curriculum for each site to establish baseline level of readiness for transformation • Focus of assessment to be on strengths and gaps in workforce, infrastructure, and workflows as they relate to capabilities and transformation milestones, prioritizing areas for improvement
Practice transformation support curriculum	• A standard curriculum that can be tailored for each Health Link site based on the needs identified in the pre-transformation assessment • Will cover 1st and 2nd years of transformation including frequency and structure of learning activities • Curriculum may include content structured through the following: – Learning collaboratives – Large format in-person trainings – Live webinars – Recorded trainings – On-site coaching
Semi-annual assessment	• Conduct assessments of progress toward each provider transformation milestone every 6 months; document progress

SOURCE: State of Arkansas Office of Procurement Request for Qualifications

Patient engagement for Health Links

Patient actions to reinforce

- Adherence to primary care, behavioral health, and specialist appointments
- Adherence to medication
- Reduced risk factor activity (e.g., exercise, less smoking)
- Enhanced reliance on Health Link and PCMH crisis support

Mechanisms to encourage patient engagement

- **Skill building** on health literacy and self-care
- **Motivational interviewing**
- **Peer support** and/or peer recovery services
- **Scheduling, follow-up, and reminders**
- **In-person** accompaniment to appointments
- **Facesheets or dashboards** to support patient recognition and relationship
- **Incentives where possible** (e.g., meals, cell phone minutes)
- **Training curriculum** to address patient engagement including **standard materials** for physical health

Health Links will have the flexibility to innovate on how they will engage patients

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Health Link provider report design

- **Health Link Overview**
  - **Basic information** (e.g., assigned members)
  - Practice Support progress review (e.g., **training milestones**)
- **Quality performance report**
  - Progress against **previous performance**
  - Comparisons to **peer organizations and State and national benchmarks where available**
- **Efficiency performance report**
  - Progress against **previous performance**
  - Comparisons to **peer organizations and State and national benchmarks where available**
- **Reporting-only measures** (e.g., total cost of care)